REMICADE® (infliximab)
BILLING GUIDE

**REMICADE® is indicated for:**

**Crohn's Disease**
- Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease (CD) who have had an inadequate response to conventional therapy.
- Reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing CD.

**Pediatric Crohn's Disease**
- Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active CD who have had an inadequate response to conventional therapy.

**Ulcerative Colitis**
- Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response to conventional therapy.

**Pediatric Ulcerative Colitis**
- Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active UC who have had an inadequate response to conventional therapy.

**Rheumatoid Arthritis**
- Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate (MTX).

**Psoriatic Arthritis**
- Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis (PsA).

**Ankylosing Spondylitis**
- Reducing signs and symptoms in patients with active ankylosing spondylitis (AS).

**Plaque Psoriasis**
- The treatment of adult patients with chronic severe (ie, extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate. REMICADE® should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician.

**SELECTED IMPORTANT SAFETY INFORMATION**

Serious and sometimes fatal side effects have been reported with REMICADE® (infliximab). Infections due to bacterial, mycobacterial, invasive fungal, viral, or other opportunistic pathogens (eg, TB, histoplasmosis) have been reported. Lymphoma, including cases of fatal hepatosplenic T-cell lymphoma (HSTCL), and other malignancies have been reported, including in children and young adult patients. Due to the risk of HSTCL, mostly reported in Crohn's disease and ulcerative colitis, assess the risk/benefit, especially if the patient is male and is receiving azathioprine or 6-mercaptopurine treatment. REMICADE® is contraindicated in patients with severe hypersensitivity reactions to REMICADE® and certain patients with congestive heart failure. Other serious side effects reported include melanoma, Merkel cell carcinoma, invasive cervical cancer, hepatitis B reactivation, hepatotoxicity, hematological events, hypersensitivity, cardiovascular and cerebrovascular reactions during and after infusion, neurological events, and lupus-like syndrome.

Please see related and other Important Safety Information on pages 22 and 23.
Janssen Biotech, Inc., is committed to providing you with detailed information to assist you in obtaining reimbursement for REMICADE®. This Billing Guide has been developed to provide you with information regarding:

- Essential Coding Considerations
- Sample Claims Forms
- Important Product Information
- Reimbursement Support Resources

Information about REMICADE® access and reimbursement support resources, for both providers and patients, is available through Janssen CarePath. Please call 877-CarePath (877-227-3728) to speak with a Janssen Care Coordinator about any reimbursement-related questions or concerns.

**Disclaimer**

Third-party reimbursement is affected by many factors. This document and the information and assistance provided by Janssen CarePath are presented for informational purposes only. They do not constitute reimbursement or legal advice. Janssen CarePath does not promise or guarantee coverage, levels of reimbursement, or payment.

Similarly, all CPT® and HCPCS codes are supplied for informational purposes only and represent no statement, promise, or guarantee, expressed or implied, by Janssen or its third-party service providers that these codes will be appropriate or that reimbursement will be made. The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the Medicare program.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. Accordingly, the information may not be current or comprehensive. Janssen and its third-party service providers strongly recommend you consult your payer for its most current coverage, reimbursement, and coding policies. Janssen and its third-party service providers make no representations or warranties, expressed or implied, as to the accuracy of the information provided. In no event shall the third-party service providers or Janssen, or their employees or agents, be liable for any damages resulting from or relating to any information provided by, or accessed to or through, Janssen CarePath. All HCPs and other users of this information agree that they accept responsibility for the use of this program.

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REMICADE® INDICATIONS AND USAGE

REMICADE® is a tumor necrosis factor (TNF) blocker indicated for:

**Crohn’s Disease**
- Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn’s disease (CD) who have had an inadequate response to conventional therapy
- Reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing CD

**Pediatric Crohn’s Disease**
- Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active CD who have had an inadequate response to conventional therapy

**Ulcerative Colitis**
- Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response to conventional therapy

**Pediatric Ulcerative Colitis**
- Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active UC who have had an inadequate response to conventional therapy

**Rheumatoid Arthritis**
- Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate (MTX)

**Psoriatic Arthritis**
- Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis (PsA)

**Ankylosing Spondylitis**
- Reducing signs and symptoms in patients with active ankylosing spondylitis (AS)

**Plaque Psoriasis**
- The treatment of adult patients with chronic severe (ie, extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate
- REMICADE® should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician

*Pediatric use is not addressed within this reimbursement guide.

Please refer to the full Prescribing Information for complete information on REMICADE® indications.
REMICADE® dosing is weight based and indication specific. Both induction and maintenance doses are administered by intravenous infusion over a period of not less than 2 hours.

**Table 1. Recommended REMICADE® Dosage and Intervals**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Induction</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crohn's Disease*</td>
<td>5 mg/kg 0, 2 &amp; 6 weeks</td>
<td>5 mg/kg† every 8 weeks</td>
</tr>
<tr>
<td>Ulcerative Colitis</td>
<td>5 mg/kg 0, 2 &amp; 6 weeks</td>
<td>5 mg/kg every 8 weeks</td>
</tr>
<tr>
<td>Rheumatoid Arthritis§</td>
<td>3 mg/kg† 0, 2 &amp; 6 weeks</td>
<td>3 mg/kg‡ every 8 weeks</td>
</tr>
<tr>
<td>Ankylosing Spondylitis</td>
<td>5 mg/kg 0, 2 &amp; 6 weeks</td>
<td>5 mg/kg every 6 weeks</td>
</tr>
<tr>
<td>Psoriatic Arthritis</td>
<td>5 mg/kg 0, 2 &amp; 6 weeks</td>
<td>5 mg/kg every 8 weeks</td>
</tr>
<tr>
<td>Plaque Psoriasis</td>
<td>5 mg/kg 0, 2 &amp; 6 weeks</td>
<td>5 mg/kg every 8 weeks</td>
</tr>
</tbody>
</table>

*Patients who do not respond by Week 14 are unlikely to respond with continued dosing and consideration should be given to discontinuing REMICADE® in these patients.
†For adult patients who respond and then lose their response, consideration may be given to treatment with 10 mg/kg.
‡In conjunction with methotrexate.
§For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg or treating as often as every 4 weeks bearing in mind that risk of serious infections is increased at higher doses.
Preparation and Administration of REMICADE® for IV Infusion

REMICADE® is supplied as 100 mg lyophilized infliximab in a 20-mL vial. REMICADE® is intended for use under the guidance and supervision of a physician. The reconstituted infusion solution should be prepared by a trained medical professional using aseptic technique. REMICADE® is administered by intravenous infusion over a period of not less than 2 hours.

1. Calculate the dose, total volume of reconstituted REMICADE® solution required, and the number of REMICADE® vials needed based on the patient’s weight and indication.

2. Reconstitute each REMICADE® vial with 10 mL of Sterile Water for Injection, USP, using a syringe equipped with a 21-gauge or smaller needle as follows:
   - Remove the flip-top from the vial and wipe the top with an alcohol swab. Insert the syringe needle into the vial through the center of the rubber stopper and direct the stream of Sterile Water for Injection, USP, to the glass wall of the vial.
   - Gently swirl the solution by rotating the vial to dissolve the lyophilized powder. Avoid prolonged or vigorous agitation. DO NOT SHAKE. Foaming of the solution on reconstitution is not unusual.
   - Allow the reconstituted solution to stand for 5 minutes. The solution should be colorless to light yellow and opalescent, and the solution may develop a few translucent particles as infliximab is a protein. Do not use if the lyophilized cake has not fully dissolved or if opaque particles, discoloration, or other foreign particles are present.

3. Dilute the total volume of the reconstituted REMICADE® solution dose to 250 mL with sterile 0.9% Sodium Chloride Injection, USP, by withdrawing a volume equal to the volume of reconstituted REMICADE® from the 0.9% Sodium Chloride Injection, USP, 250-mL bottle or bag. Do not dilute the reconstituted REMICADE® solution with any other diluent. Slowly add the total volume of reconstituted REMICADE® solution to the 250-mL infusion bottle or bag. Gently mix. The resulting infusion concentration should range between 0.4 mg/mL and 4 mg/mL.

4. The REMICADE® infusion should begin within 3 hours of reconstitution and dilution. The infusion must be administered over a period of not less than 2 hours and must use an infusion set with an in-line, sterile, non-pyrogenic, low-protein-binding filter (pore size of 1.2-μm or less). REMICADE® vials do not contain preservatives. Therefore, any unused portion of the infusion solution should be discarded and not be stored for reuse.

5. REMICADE® should not be infused concomitantly in the same intravenous line with other agents.

6. Parenteral drug products should be inspected visually before and after reconstitution for particulate matter and discoloration prior to administration, whenever solution and container permit. If visibly opaque particles, discoloration or other foreign particulates are observed, the solution should not be used.

Please refer to the Dosage and Administration section of the full Prescribing Information for complete information on how to prepare and administer REMICADE®.
CODING FOR REMICADE®

ICD-10-CM Diagnosis Codes

All parties covered by HIPAA, not just providers who bill Medicare or Medicaid, are required to use the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes to document patient diagnoses. ICD-10-CM far exceeds previous coding systems in the number of concepts and codes provided, allowing for greater specificity when describing patient conditions. ICD-10-CM uses 3-7 alpha and numeric characters to achieve this level of detail. Although it is not necessary to use all 7 characters, coding to the highest level of specificity is required.

Table 2. ICD-10-CM Codes* for Consideration

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K50.00</td>
<td>Crohn's disease of small intestine without complications</td>
</tr>
<tr>
<td>K50.10</td>
<td>Crohn's disease of large intestine without complications</td>
</tr>
<tr>
<td>K50.80</td>
<td>Crohn's disease of both small and large intestine without complications</td>
</tr>
<tr>
<td>K50.90</td>
<td>Crohn's disease, unspecified, without complications</td>
</tr>
</tbody>
</table>

Fistula (use in addition to codes for Crohn's Disease)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K60.3</td>
<td>Anal fistula</td>
</tr>
<tr>
<td>K60.4</td>
<td>Rectal fistula</td>
</tr>
</tbody>
</table>

Ulcerative Colitis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K51.80</td>
<td>Other ulcerative colitis without complications</td>
</tr>
<tr>
<td>K51.20</td>
<td>Ulcerative (chronic) proctitis without complications</td>
</tr>
<tr>
<td>K51.30</td>
<td>Ulcerative (chronic) rectosigmoiditis without complications</td>
</tr>
<tr>
<td>K51.50</td>
<td>Left-sided colitis without complications</td>
</tr>
<tr>
<td>K51.00</td>
<td>Ulcerative (chronic) pancolitis without complications</td>
</tr>
<tr>
<td>K51.90</td>
<td>Ulcerative colitis, unspecified, without complications</td>
</tr>
</tbody>
</table>

Rheumatoid Arthritis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M06.00</td>
<td>Rheumatoid arthritis w/o rheumatoid factor, unspecified</td>
</tr>
<tr>
<td>M05.60</td>
<td>Rheumatoid arthritis of unspecified site with involvement of other organs and systems</td>
</tr>
<tr>
<td>M05.70</td>
<td>Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement</td>
</tr>
</tbody>
</table>

Ankylosing Spondylitis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M45.9</td>
<td>Ankylosing spondylitis of unspecified sites in spine</td>
</tr>
</tbody>
</table>

Psoriatic Arthritis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L40.50</td>
<td>Arthropathic psoriasis, unspecified</td>
</tr>
</tbody>
</table>

Plaque Psoriasis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L40.0</td>
<td>Plaque psoriasis</td>
</tr>
</tbody>
</table>

*These codes are not intended to be promotional or to encourage or suggest a use of drug that is inconsistent with FDA-approved use. The codes provided are not exhaustive and additional codes may apply. Listed codes may require a higher level of specificity when reporting for individual patients.

Please see Important Safety Information on pages 22 and 23.
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CODING FOR REMICADE® (cont’d)

National Drug Code (NDC)

The National Drug Code (NDC) is a unique number that identifies a drug’s labeler, product, and trade package size. The NDC has typically been reserved for pharmacy billing, including drugs provided for home infusion. However, Medicaid fee-for-service programs and some private payers now also require the NDC for billing instead of, or in addition to, the HCPCS code, for physician claims and those of other service providers. Although the FDA uses a 10-digit format when registering NDCs, payer requirements regarding the use of the 10- or 11-digit NDC may vary. Electronic data exchange generally requires use of the 11-digit NDC. To convert the 10-digit format to the 11-digit format, insert a leading zero into the middle sequence, as illustrated below. In some cases, you may be required to include the NDC number on a claim form.

<table>
<thead>
<tr>
<th>10-digit NDC</th>
<th>11-digit NDC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57894-030-01</td>
<td>57894-0030-01</td>
<td>Single-use vial containing 100 mg of infliximab for final reconstitution volume of 10 mL</td>
</tr>
</tbody>
</table>

NDC Units

The NDC unit of measure is determined by how the drug is supplied. In the outpatient setting, UN (unit) applies to drugs supplied in a vial in powder form, requiring reconstitution before administration, and ML (milliliters) applies to drugs supplied in vials in liquid form. NDC units dispensed are based on the packaging and numeric quantity administered to the patient. Here is an example for a 400-mg dose of REMICADE®:

<table>
<thead>
<tr>
<th>Dose to Be Billed</th>
<th>NDC (11-digit)</th>
<th>Packaging</th>
<th>NDC Unit of Measure</th>
<th>NDC Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>400 mg</td>
<td>5789-0030-01</td>
<td>100-mg vial (powder)</td>
<td>UN</td>
<td>4</td>
</tr>
</tbody>
</table>

In this example the drug is supplied in 100-mg vials, in powder form for reconstitution. The NDC is specific to the packaging, thus one 100-mg vial equals 1 NDC unit. The total dose to be billed is 400 mg (400 divided by 100), or 4 NDC units. The drug is packaged in powder form so the unit of measure is “UN.” Accurate NDC coding typically requires the following components:

- Reporting the NDC with 11 digits in a 5-4-2 configuration; this may require converting a 10-digit NDC to an 11-digit NDC
- Reporting the correct NDC unit of measure (ie, UN, ML)
- Reporting the number of NDC units dispensed
- Reporting the qualifier, N4, in front of the NDC

Using the same 400-mg REMICADE® example, here is how this format would appear:

N457894003001 UN4

Payer requirements for NDC use and format may vary. Please contact your payers for specific coding policies and more information on correct billing and claims submission. For additional support, you may contact Janssen CarePath at [https://www.JanssenCarePath.com/hcp/remicade](https://www.JanssenCarePath.com/hcp/remicade) or 877-CarePath (877-227-3728).

Please see Important Safety Information on pages 22 and 23.
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CODING FOR REMICADE® (cont’d)

Healthcare Common Procedure Code System (HCPCS) Level II Codes

Drugs are typically reported using product-specific HCPCS codes (e.g., J codes) assigned by the Centers for Medicare & Medicaid Services (CMS). HCPCS units are determined by the specific HCPCS descriptor. The descriptor is not necessarily the same as the package or therapeutic dose so the dose must be converted to billable HCPCS units to accurately complete a claim. The HCPCS code for REMICADE® is:

J1745 - Injection, infliximab, excludes biosimilar, 10 mg

Each 100-mg vial of drug represents 10 units of J1745, thus each 10-mg dose of REMICADE® equals one billing unit, or 1/10th of a vial. When coding for J1745, report the total number of 10-mg increments administered. Table 5 illustrates the correlation between REMICADE® vials, milligrams, and billing units.

<table>
<thead>
<tr>
<th>Number of 100-mg vials of infliximab</th>
<th>Total milligrams (mg)</th>
<th>Number of billing units based on J1745 (10 mg infliximab per unit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>200</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>300</td>
<td>30</td>
</tr>
<tr>
<td>4</td>
<td>400</td>
<td>40</td>
</tr>
</tbody>
</table>
CODING FOR DRUG ADMINISTRATION

Coding for Drug Administration Services

This section reviews general coding guidelines for drug administration services coded by physician offices using the CMS-1500 claim form and by hospital outpatient departments using the CMS-1450 (UB-04) claim form. Please note that healthcare providers are responsible for selecting appropriate codes for any particular claim based on the patient’s condition, the items and services that are furnished, and any specific payer requirements. It is advisable to contact your local payer with regard to local payment policies.

Codes for Drug Administration

Drug administration services are reported on claim forms in both the physician office (CMS-1500) and hospital outpatient (CMS-1450) sites of care using the CPT® coding system. The CPT® codes most commonly associated with the administration of REMICADE® are:

- 96413 - Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug, and
- 96415 - Each additional hour (Use 96415 in conjunction with 96413; report 96415 for infusion intervals of greater than 30 minutes beyond 1-hour increments.)

These codes, often referred to as “complex” codes, apply to the parenteral administration of chemotherapy and also anti-neoplastic agents provided for treatment of non-cancer diagnoses, or to substances such as certain monoclonal antibodies and other biologic response modifiers. Complex drug administration services also require special considerations to prepare, dose, or dispose and typically entail professional skill and patient monitoring significantly beyond that required for therapeutic infusions.

Alternatively, some payers may require the use of CPT® codes:

- 96365 - Intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour, and
- 96366 - Each additional hour (List separately in addition to code for primary procedure; report 96366 for infusion intervals of greater than 30 minutes beyond 1-hour increments.)

These codes, often referred to as “therapeutic” codes, typically require special considerations to prepare, dose, or dispose of the drug/biological and necessitate special training and competency for the staff who administer them. These services generally require periodic patient assessment during and/or after the procedure.

Payer policies for codes used to describe infusion services may vary. Consult your payers for policies regarding use of 96413 and 96415 or 96365 and 96366. For additional assistance, contact Janssen CarePath at https://www.JanssenCarePath.com/hcp/remicade or 877-CarePath (877-227-3728).

Partial Additional Hours of Infusion Time

CMS has a policy for reporting the add-on infusion codes when less than a full hour of service is provided. Providers may report the add-on infusion code for “each additional hour” only if the infusion interval is greater than 30 minutes beyond the 1-hour increment. For example, if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the provider would report the “initial” code up to 1 hour and the add-on code for the additional 45 minutes. If the incremental amount of infusion time is 30 minutes or less the time is not to be billed separately. Note that some payers may require reporting the actual number of minutes on the claim.
OTHER CODING CONSIDERATIONS

Place of Service Codes

The Place of Service (POS) code set provides setting information necessary to appropriately pay professional service claims. The place of service is the location of the provider’s face-to-face encounter with the beneficiary. POS codes are required on all claims for professional services (billed on CMS-1500). Under the Physician Fee Schedule (PFS), some procedures have separate rates for professional services when provided in facility and nonfacility settings; therefore it is important to accurately designate the POS to assure appropriate payment. The physician practice location is considered “nonfacility” (NF), allowing for the practice expenses to be included in the payment under the Physician Fee Schedule (PFS). When professional services are performed in a facility (eg, hospital outpatient department), the practice does not incur the same expense (overhead, staff, equipment and supplies, etc), thus, payment under the PFS is generally lower for facility-based services than for NF.

The physician practice setting is indicated with POS code 11. To differentiate between on-campus and off-campus provider-based departments, CMS created a new POS code (POS 19) and revised the POS code description for outpatient hospital (POS 22). Professional services delivered in outpatient hospital settings must now specifically include the off-campus or on-campus POS on the claim form.

### Table 6. Place of Service Codes

<table>
<thead>
<tr>
<th>POS Code</th>
<th>POS Name</th>
<th>POS Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
<td>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus – Outpatient Hospital</td>
<td>A portion of an off-campus hospital provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)</td>
</tr>
<tr>
<td>22</td>
<td>On Campus – Outpatient Hospital</td>
<td>A portion of a hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)</td>
</tr>
</tbody>
</table>

Revenue Codes

Many payers require use of American Hospital Association (AHA) revenue codes to bill for services provided in hospital outpatient departments. Revenue codes consist of a leading zero followed by three other digits and are used on claim forms to assign costs to broad categories of hospital revenue centers. Codes used for Medicare claims are available from Medicare contractors. The following revenue codes may be applicable to CMS-1450 claims for drugs and their administration:

- 0260 IV Therapy, General
- 0510 Clinic, General
- 0636 Pharmacy, drugs requiring detailed coding

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HCPCS and CPT® Modifiers

Modifiers provide a means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. They add more information and help to eliminate the appearance of duplicate billing and unbundling. Appropriately used, modifiers increase coding and reimbursement accuracy.

The following table summarizes modifiers that may be applicable to drug and drug administration coding in physician offices and hospital outpatient departments.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Indication and Placement</th>
<th>CMS-1500 (Item 24D)</th>
<th>CMS-1450 (Box 44)</th>
</tr>
</thead>
</table>
| 25       | Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service | • Patient requires distinct E/M service in addition to the infusion procedure<sup>5</sup>  
• Must be substantiated by documentation that supports the relevant criteria for the reported E/M code<sup>5</sup>  
• Append the modifier to the appropriate E/M code<sup>5</sup> | ✓ | ✓ |
| JW       | Drug amount discarded/not administered to any patient<sup>4</sup> | • Applies only to the unused drug that is discarded after applicable dose has been administered from a single-use vial<sup>9</sup>  
• Append the modifier to the drug code on a line separate from that reporting the administered dose<sup>9</sup> | ✓ | ✓ |
| PO*      | Excepted services provided at an off-campus, outpatient provider-based department of a hospital<sup>4</sup> | • To be reported on each claim line for excepted services furnished in an off-campus, provider-based department of a hospital and billed on an institutional claim<sup>10</sup> | N/A | ✓ Required by Medicare |
| PN*      | Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital<sup>4</sup> | • To be reported on each claim line for non-excepted services furnished in an off-campus provider-based department of a hospital and billed on an institutional claim<sup>10</sup> | N/A | ✓ Required by Medicare |
| JG       | Drug or biological acquired with 340B Drug Pricing Program Discount<sup>4</sup> | • Must be reported by providers that are NOT excepted<sup>†</sup> from the 340B payment policy<sup>11</sup>  
• To be reported on the same claim line as the drug HCPCS code for all 340B acquired drugs<sup>11</sup> | N/A | ✓ Required by Medicare |
| TB       | Drug or biological acquired with 340B Drug Pricing Program Discount, reported for informational purposes<sup>4</sup> | • Must be reported by providers that ARE excepted<sup>†</sup> from the 340B payment policy<sup>11</sup>  
• To be reported on the same claim line as the drug HCPCS code for all 340B acquired drugs<sup>11</sup> | N/A | ✓ Required by Medicare |

<sup>4</sup>Neither the PO nor the PN modifier is to be reported for dedicated emergency departments, remote locations or satellite facilities of a hospital, or a provider-based department that is “on campus.”<sup>10</sup>

<sup>5</sup>The 340B payment policy does not apply to critical access hospitals (CAHs) or Maryland hospitals; for 2019, the following provider types are excepted from the 340B payment policy: rural sole community hospitals, children’s hospitals, and PPS-exempt cancer hospitals.<sup>11</sup>

Please see Important Safety Information on pages 22 and 23.

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OTHER CODING CONSIDERATIONS (cont’d)

Same Day Evaluation and Management Services
It may be necessary to provide evaluation and management (E/M) services on the same day as a drug administration procedure. Depending on the payer, E/M services that are medically necessary, separate, and distinct from the drug administration procedure, and documented appropriately, are generally covered.

CMS has a specific policy regarding use of CPT® code 99211 (level 1 medical visit for an established patient) in the physician office:

For services furnished on or after January 1, 2004, do not allow payment for CPT® code 99211, with or without modifier 25, if it is billed with a non-chemotherapy drug infusion code or a chemotherapy administration code. Apply this policy to code 99211 when it is billed with a diagnostic or therapeutic injection code on or after January 1, 2005.⁶

This means that a level 1 medical visit for an established patient (99211) cannot be billed on the same day as an office-based therapeutic or complex infusion or injection.

CMS Discarded Drug Policy⁹
When a physician, hospital or other provider or supplier must discard the remainder of a single-use vial or other single-use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Medicare contractors require the modifier JW to identify unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded. This modifier, billed on a separate claim line, supports payment for the amount of discarded drug or biological.

For example, a single-use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95-unit dose is billed on one line, while the discarded 5 units is billed on another line accompanied by the JW modifier. Both line items will be processed for payment.

Providers must record the discarded amounts of drugs and biologicals in the patient’s medical record.

JW Modifier Summary
• Payment for discarded amounts of drug/biological applies only to single-use vials or packages
• Multi-use vials are not subject to payment for discarded amounts
• Discarded amounts of drugs/biologicals must be recorded in the patient’s medical record
• Medicare contractors require the JW modifier; other payer policies may vary

Patient-Supplied Drugs
Medicare Part B covers drugs that are furnished incident to a physician’s service, provided the drugs are not usually self-administered by the patients who take them, and are reasonable and necessary for the diagnosis or treatment of the illness or injury per accepted standards of medical practice. To meet all the general requirements for coverage under the incident to provision, an FDA-approved drug or biological must be furnished by a physician and administered by the physician or by auxiliary personnel employed by the physician and under the physician’s personal supervision. The charge for the drug or biological must be included in the physician’s bill, and the cost of the drug or biological must represent an expense to the physician.

Alternatively payers, including Medicare Part D, may cover the drug under the patient’s pharmacy benefit. Under this model, the drug may be directly obtained by the patient and brought to the site of care for administration (“brown bagging”) or may be delivered to the administering site via a specialty pharmacy channel (“white bagging”). Under certain circumstances, qualified patients may acquire donated or no-cost drug. When the drug is purchased by the beneficiary, or when the drug was supplied without charge by a third party, it should NOT be billed to Medicare by the physician. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.¹²

When reporting drug administration services for patient-supplied drugs, it may be necessary to include drug information on the claim and enter “0.01” charges.¹³ Payer policies may vary.

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Remicade®
INFLIXIMAB

Janssen Immunology
PHARMACEUTICAL COMPANIES OF JANSSEN PHARMACEUTICALS, JANSSEN BIO pharma, AND JANSSEN NEUROSCIENCES
SAMPLE CLAIM FORMS

Physician Office Claims (CMS-1500)

The Form CMS-1500 is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from suppliers and non-institutional providers that qualify for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It has also been adopted by the TRICARE Program. For detailed guidance on completing the CMS-1500 items, please see the Medicare Claims Processing Manual, Pub. 100-04, Chapter 26, available at:

The 837P (Professional) is the standard format used by healthcare professionals and suppliers to transmit healthcare claims electronically. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic claim version. Data elements in the CMS uniform electronic billing specifications are consistent with the hard copy data set to the extent that one processing system can handle both. Medicare Administrative Contractors may include a crosswalk between the ASC X12N 837P and the CMS-1500 on their websites.

Hospital Outpatient Claims (CMS-1450)

The Form CMS-1450, also known as the UB-04, is a uniform institutional provider bill suitable for use in billing multiple third-party payers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from hospitals, including HOPDs. Because it serves many payers, a particular payer may not need some data elements. For detailed guidance on completing the CMS-1450 items, please see the Medicare Claims Processing Manual, Pub. 100-04, Chapter 25, available at:

The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837I (Institutional) Version 5010A2 is the current electronic claim version. Data elements in the uniform electronic billing specifications are consistent with the hard copy data set to the extent that one processing system can handle both. Medicare Administrative Contractors may include a crosswalk between the ASC X12N 837I and the CMS-1450 on their websites.

For more information on electronic claims, please see the CMS website at:

Please see Important Safety Information on pages 22 and 23.
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### SAMPLE CLAIM FORMS (cont’d)

**REMICADE® (infliximab)**

**2019 Physician Office Sample Claim Form: CMS-1500**

#### HEALTH INSURANCE CLAIM FORM

- **APPROVED OMB-0938-1197 FORM 1500 (02-12)**

**PLEASE PRINT OR TYPE**

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</table>

**REMICADE® (infliximab)**

2019 Physician Office Sample Claim Form: CMS-1500

Please see Important Safety Information on pages 22 and 23.

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SAMPLE CLAIM FORMS (cont’d)

REMICADE® (infliximab)
2019 Physician Office Sample Claim Form: CMS-1500

1. Item 19—Some payers may require additional information (e.g., a statement that the patient is on concomitant methotrexate) or additional codes such as the NDC. Payer requirements may vary.*

2. Item 21—Indicate diagnosis/diagnoses using appropriate ICD-10-CM codes. Use diagnosis codes to the highest level of specificity for the date of service and enter the diagnoses in priority order. The “ICD Indicator” identifies the ICD code set being reported. For ICD-10-CM diagnoses enter 0 (zero) as a single digit between the vertical, dotted lines.

3. Item 24D—Indicate appropriate CPT® and HCPCS codes and modifiers if required.

REMICADE®
J1745 - Injection, infliximab, excludes biosimilar, 10 mg

If line item NDC information is required, it will be entered in the shaded portion of Item 24A.† For example:

If payer requirements for NDC entries may vary.*

Infusion Services*
96413 - Chemotherapy administration, intravenous infusion technique; up to 1 hour
96415 - Each additional hour

4. When it is necessary to discard the remainder of a single-use vial after administering a dose of drug/biological to a Medicare patient, the program provides payment for the amount discarded as well as the dose administered. Medicare requires the modifier JW be appended to the discarded amount, billed on a separate line from the administered dose. Other payer policies may vary.*

5. Item 24E—Refer to the diagnosis for this service (see Box 21). Enter only one diagnosis pointer.

6. Item 24G—Enter the number of HCPCS units: 10 mg = 1 unit (100-mg vial = 10 units).

*Contact your local payer or Janssen CarePath at 877-CarePath (877-227-3728) to confirm payer requirements. For additional resources, visit Janssen CarePath at https://www.JanssenCarePath.com/hcp/remicade.

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### REMICADE® (infliximab)

#### 2019 HOPD Sample Claim Form: CMS-1450 (UB-04)

- **Claim Form Example**
  - **Claim ID**: 9641501-02-169641501-02-15
  - **Procedure Code**: 0260, 0636
  - **Drug Code**: J1745, J1745JW

### Important Notes

- **Please see Important Safety Information on pages 22 and 23.**
- **Back to Table of Contents.**
SAMPLE CLAIM FORMS (cont’d)

REMICADE® (infliximab)
2019 HOPD Sample Claim Form: CMS-1450 (UB-04)

1. Locator Box 42—List revenue codes in ascending order.

2. Locator Box 43—Enter narrative description for corresponding revenue code (eg, IV therapy, drug). If line item NDC information is required it will be entered in the unshaded portions of Locator Box 43. Payer requirements for NDC entries may vary.*

3. Locator Box 44—Indicate appropriate CPT® and HCPCS codes and modifiers as required by payer.

REMICADE®
J1745 - Injection, infliximab, excludes biosimilar, 10 mg
Infusion Services*
96413 - Chemotherapy administration, intravenous infusion technique; up to 1 hour
96415 - Each additional hour

NOTE: HCPCS modifiers must be reported by all off-campus hospital outpatient departments. The PO modifier is to be reported with every HCPCS code for all items and services furnished in an excepted, off-campus, provider-based department of a hospital. The PN modifier is to be reported on each claim line for all items and services furnished in a nonexcepted, off-campus, provider-based department of a hospital.¹⁰

NOTE: HCPCS modifiers must be reported for all 340B-acquired drugs. Providers that are not excepted from the 340B payment policy will report modifier JG. Providers that are excepted from the 340B payment policy will report modifier TB.¹¹

4. Locator Box 46—Enter the number of HCPCS units: 10 mg = 1 unit (100-mg vial = 10 units).

5. When it is necessary to discard the remainder of a single-use vial after administering a dose of drug/biological to a Medicare patient, the program provides payment for the amount discarded as well as the dose administered. Medicare requires the modifier JW be appended to the discarded amount, billed on a separate line from the administered dose.² Other payer policies may vary.*

6. Locator Box 47—Indicate total charges.

7. Locator Box 67—Indicate diagnosis using appropriate ICD-10-CM codes. Use diagnosis codes to the highest level of specificity for the date of service and enter the diagnoses in priority order.

*Contact your local payer or Janssen CarePath at 877-CarePath (877-227-3728) to confirm payer requirements. For additional resources, visit Janssen CarePath at https://www.JanssenCarePath.com/hcp/remicade.

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COVERAGE CONSIDERATIONS

Factors That Influence Coverage
Third-party payers (eg, commercial insurers, Medicare, Medicaid) will generally cover parenteral drugs for their approved U.S. Food and Drug Administration indications, and the associated professional administration services. However, benefits may vary depending upon the payer and the specific plan (“insurance product”) in which a patient is enrolled.

Medical Necessity
When third-party payers review infusible drug claims, they will first determine if the type of service provided is covered under their policies. Next, payers will look for evidence supporting the medical necessity of the therapy. This evidence may include:

- Information about the patient’s medical condition and history
- A physician’s statement or Letter of Medical Necessity
- Supporting literature (eg, peer-reviewed studies and compendia monographs)
- Full Prescribing Information
- Availability of other treatment alternatives

Medical necessity refers to a decision by a health plan that a treatment, test, or procedure is necessary for health or to treat a diagnosed medical problem. Health insurance companies provide coverage only for health-related services that they define or determine to be medically necessary. Medicare National Coverage Determinations (NCDs) and Medicare Administrative Contractors (MACs) Local Coverage Determinations (LCDs) define medical necessity requirements for Medicare coverage. These documents contain guidance on covered diagnoses, required documentation, and limitations of coverage for specific services in accordance with medical necessity.

Administrative Considerations
Other considerations may be involved in a payer's decision to cover a product or service:

- Does the payer cover the therapy only when provided through a specific treatment site?
  Payers may have site-specific coverage rules that restrict provision of infused therapies. For example, currently Medicare does not cover infusions when they are billed by Medicare-certified ambulatory surgery centers. Payers also may restrict coverage for certain infused drugs in the home or hospital outpatient setting.

- Is the billing provider a “participating” member of, or “in-network” provider for, that particular plan?
  Payers contract with providers to deliver services to the plan’s members. Providers are thus “participating” or within that plan’s network, requiring them to abide by the contract charge structure when providing care for that plan’s members.

- If required by the plan, has the appropriate referral or prior authorization been obtained?
  Many plans require that non-emergency services be pre-approved or that a primary care physician make the referral for specialty care. Failing to obtain appropriate referrals or pre-authorization can result in non-payment by the plan.

Please see Important Safety Information on pages 22 and 23.
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Janssen CarePath is your one source for access, affordability, and treatment support for your patients

Access support to help navigate payer processes

Janssen CarePath helps verify insurance coverage for your patients taking REMICADE® and provides reimbursement information.

Our electronic resources available at www.JanssenCarePathPortal.com include:

- eBenefits investigations
- ePrior authorization support and status monitoring
  - Payer-specific Prior Authorization (PA) forms delivered in Portal
- eCreation of medical necessity and exceptions letters
- eRequest for exceptions and appeals information
- Online coding and billing information
- Online Live Chat feature to answer questions

Affordability support to help your patients start and stay on the Janssen treatment you prescribe

Janssen CarePath can help you find out what affordability assistance may be available for your patients taking REMICADE®.

Support for patients using commercial or private insurance:

- **Janssen CarePath Savings Program** allows eligible patients to save on their out-of-pocket medication costs. Depending on the health insurance plan, savings may apply toward co-pay, co-insurance, or deductible.
  - Eligible patients **pay $5 for each infusion**, with a $20,000 maximum program benefit per calendar year.
  - Not valid for patients using Medicare, Medicaid, or other government-funded programs to pay for their medications. Terms expire at the end of each calendar year and may change. There is no income requirement.
  - For medication costs only; program does not cover cost to give patients their infusion.
  - The Savings Program provides a rebate when used with medical/primary insurance and provides instant savings when used with pharmacy/prescription insurance.
  - See full eligibility requirements at Remicade.JanssenCarePathSavings.com.

- Online enrollment and tracking of patient Savings Program benefits by you, the pharmacy, or the patient.
- Comprehensive Provider Portal at www.JanssenCarePathPortal.com allows you to enroll eligible patients in Savings Programs, view patients’ available benefit and transactions as directed by the patient, and receive timely alerts and program updates.

Support for patients using government-funded healthcare programs or patients without insurance coverage:

- Janssen CarePath can provide information about other resources that may be able to help your patients with their out-of-pocket medication costs, including:
  - State Pharmaceutical Assistance Programs (SPAPs)
  - State Health Insurance Programs (SHIPs)
  - Medicare Savings Program
  - Medicare Part D Extra Help—Low-Income Subsidy
  - Independent Foundations*

- Call a Janssen CarePath Care Coordinator at 877-CarePath (877-227-3728) or visit www.JanssenPrescriptionAssistance.com/Remicade for more information on affordability programs that may be available.

*Independent co-pay assistance foundations have their own rules for eligibility. We have no control over these independent foundations and can only refer your patients to a foundation that supports their disease state. We do not endorse any particular foundation.

Please see Important Safety Information on pages 22 and 23.
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Treatment support to help your patients get informed and stay on prescribed treatment

Janssen CarePath provides additional support to your patients taking REMICADE®, including:

- Care coordination with treatment provider or pharmacy
- Treatment demonstration videos
- Nurse Support to answer patients’ questions*
- Personalized treatment reminders
- Access to Care4Today® Connect mobile app
- Patient education and tools
- Infusion site locator at www.2infuse.com

Patients can manage Savings Program benefits and more on their Janssen CarePath Account at MyJanssenCarePath.com

- Enroll in the Janssen CarePath Savings Program
- Manage Savings Program benefits
- Learn about their insurance coverage
- Sign up for treatment reminders

Call a Janssen CarePath Care Coordinator at 877-CarePath (877-227-3728), Monday-Friday, 8:00 AM to 8:00 PM ET
Multilingual phone support available.

Sign Up or Log In to the Provider Portal at www.JanssenCarePathPortal.com

Visit www.JanssenCarePath.com/hcp/Remicade

Patient insurance benefits investigation and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Johnson & Johnson Health Care Systems Inc. on behalf of Janssen Biotech, Inc. (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography, and other program differences. Janssen CarePath assists healthcare providers in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the healthcare provider under appropriate authorization following the provider’s exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

*The nurse program is limited to education for patients about their Janssen therapy, its administration, and/or their disease. It is intended to supplement a patient’s understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient’s doctor or nurse, provide case management services, or serve as a reason to prescribe.

Please see Important Safety Information on pages 22 and 23.
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**IMPORTANT SAFETY INFORMATION**

**Important Safety Information**

**SERIOUS INFECTIONS**

Patients treated with REMICADE® (infliximab) are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. Discontinue REMICADE® if a patient develops a serious infection or sepsis.

Reported infections include:

- **Active tuberculosis (TB)**, including reactivation of latent TB. Patients should be tested for latent TB before and during treatment with REMICADE®. Treatment for latent infection should be initiated prior to treatment with REMICADE®.

- **Invasive fungal infections**, including histoplasmosis, coccidiodomycosis, candidiasis, aspergillosis, blastomycosis, pneumocystosis, and cryptococcosis. Patients may present with disseminated, rather than localized, disease. Empiric anti-fungal therapy should be considered in patients at risk for invasive fungal infections who develop severe systemic illness.

- **Bacterial, viral, and other infections due to opportunistic pathogens**, including Legionella, Listeria, and Salmonella.

The risks and benefits of treatment with REMICADE® should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection. Closely monitor patients for the development of signs and symptoms of infection during and after treatment with REMICADE®, including the possible development of TB in patients who tested negative for latent TB infection prior to initiating therapy, who are on treatment for latent TB, or who were previously treated for TB infection.

Risk of infection may be higher in patients greater than 65 years of age, pediatric patients, patients with co-morbid conditions and/or patients taking concomitant immunosuppressant therapy. In clinical trials, other serious infections observed in patients treated with REMICADE® included pneumonia, cellulitis, abscess, and skin ulceration.

**MALIGNANCIES**

Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, including REMICADE®. Approximately half of these cases were lymphomas, including Hodgkin’s and non-Hodgkin’s lymphoma. The other cases represented a variety of malignancies, including rare malignancies that are usually associated with immunosuppression and malignancies that are not usually observed in children and adolescents. The malignancies occurred after a median of 30 months after the first dose of therapy. Most of the patients were receiving concomitant immunosuppressants.

Postmarketing cases of hepatosplenic T-cell lymphoma, a rare type of T-cell lymphoma, have been reported in patients treated with TNF blockers, including REMICADE®. These cases have had a very aggressive disease course and have been fatal. The majority of reported REMICADE® cases have occurred in patients with Crohn’s disease or ulcerative colitis and most were in adolescent and young adult males. Almost all of these patients had received treatment with azathioprine or 6-mercaptopurine concomitantly with REMICADE® at or prior to diagnosis. Carefully assess the risks and benefits of treatment with REMICADE®, especially in these patient types.

In clinical trials of all TNF inhibitors, more cases of lymphoma were observed compared with controls and the expected rate in the general population. However, patients with Crohn’s disease, rheumatoid arthritis, or plaque psoriasis may be at higher risk for developing lymphoma. In clinical trials of some TNF inhibitors, including REMICADE®, more cases of other malignancies were observed compared with controls. The rate of these malignancies among patients treated with REMICADE® was similar to that expected in the general population whereas the rate in control patients was lower than expected. Cases of acute and chronic leukemia have been reported with postmarketing TNF-blocker use. As the potential role of TNF inhibitors in the development of malignancies is not known, caution should be exercised when considering treatment of patients with a current or a past history of malignancy or other risk factors such as chronic obstructive pulmonary disease (COPD).

Melanoma and Merkel cell carcinoma have been reported in patients treated with TNF-blocker therapy, including REMICADE®. Periodic skin examination is recommended for all patients, particularly those with risk factors for skin cancer.

A population-based retrospective cohort study found a 2- to 3-fold increase in the incidence of invasive cervical cancer in women with rheumatoid arthritis treated with REMICADE® compared to biologics-naïve patients or the general population, particularly those over 60 years of age. A causal relationship between REMICADE® and cervical cancer cannot be excluded. Periodic screening should continue in women treated with REMICADE®.

**CONTRAINDICATIONS**

REMICADE® is contraindicated in patients with moderate to severe (NYHA Class III/IV) congestive heart failure (CHF) at doses greater than 5 mg/kg. Higher mortality rates at the 10 mg/kg dose and higher rates of cardiovascular events at the 5 mg/kg dose have been observed in these patients. REMICADE® should be used with caution and only after consideration of other treatment options. Patients should be monitored closely. Discontinue REMICADE® if new or worsening CHF symptoms appear. REMICADE® should not be re-administered to patients who have experienced a severe hypersensitivity reaction or to patients with hypersensitivity to murine proteins or other components of the product.
IMPORTANT SAFETY INFORMATION (cont’d)

HEPATITIS B REACTIVATION

TNF inhibitors, including REMICADE®, have been associated with reactivation of hepatitis B virus (HBV) in patients who are chronic carriers. Some cases were fatal. Patients should be tested for HBV infection before initiating REMICADE®. For patients who test positive, consult a physician with expertise in the treatment of hepatitis B. Exercise caution when prescribing REMICADE® for patients identified as carriers of HBV and monitor closely for active HBV infection during and following termination of therapy with REMICADE®. Discontinue REMICADE® in patients who develop HBV reactivation and initiate antiviral therapy with appropriate supportive treatment. Exercise caution when considering resumption of REMICADE® and monitor patients closely.

HEPATOTOXICITY

Severe hepatic reactions, including acute liver failure, jaundice, hepatitis, and cholestasis have been reported in patients receiving REMICADE® postmarketing. Some cases were fatal or required liver transplant. Aminotransferase elevations were not noted prior to discovery of liver injury in many cases. Patients with symptoms or signs of liver dysfunction should be evaluated for evidence of liver injury. If jaundice and/or marked liver enzyme elevations (eg, ≥5 times the upper limit of normal) develop, REMICADE® should be discontinued, and a thorough investigation of the abnormality should be undertaken.

HEMATOLOGIC EVENTS

Cases of leukopenia, neutropenia, thrombocytopenia, and pancytopenia (some fatal) have been reported. The causal relationship to REMICADE® therapy remains unclear. Exercise caution in patients who have ongoing or a history of significant hematologic abnormalities. Advise patients to seek immediate medical attention if they develop signs and symptoms of blood dyscrasias or infection. Consider discontinuation of REMICADE® in patients who develop significant hematologic abnormalities.

HYPERSENSITIVITY

REMICADE® has been associated with hypersensitivity reactions that differ in their time of onset. Anaphylaxis, acute urticaria, dyspnea, and hypotension have occurred in association with infusions of REMICADE®. Medications for the treatment of hypersensitivity reactions should be available.

CARDIOVASCULAR AND CEREBROVASCULAR REACTIONS DURING AND AFTER INFUSION

Serious cerebrovascular accidents, myocardial ischemia/infarction (some fatal), hypotension, hypertension, and arrhythmias have been reported during and within 24 hours of initiation of REMICADE® infusion. Cases of transient visual loss have been reported during or within 2 hours of REMICADE® infusion. Monitor patients during infusion and if a serious reaction occurs, discontinue infusion. Manage reactions according to signs and symptoms.

NEUROLOGIC EVENTS

TNF inhibitors, including REMICADE®, have been associated with CNS manifestation of systemic vasculitis, seizure, and new onset or exacerbation of CNS demyelinating disorders, including multiple sclerosis and optic neuritis, and peripheral demyelinating disorders, including Guillain-Barré syndrome. Exercise caution when considering REMICADE® in patients with these disorders and consider discontinuation if these disorders develop.

AUTOIMMUNITY

Treatment with REMICADE® may result in the formation of autoantibodies and in the development of a lupus-like syndrome. Discontinue treatment if symptoms of a lupus-like syndrome develop.

ADVERSE REACTIONS

In clinical trials, the most common REMICADE® adverse reactions occurring in >10% of patients included infections (eg, upper respiratory, sinusitis, and pharyngitis), infusion-related reactions, headache, and abdominal pain.

USE WITH OTHER DRUGS

Concomitant use of REMICADE® with anakinra, abatacept, tocilizumab, or other biologics used to treat the same conditions as REMICADE® is not recommended because of the possibility of an increased risk of infection. Care should be taken when switching from one biologic to another, since overlapping biological activity may further increase the risk of infection.

LIVE VACCINES/THERAPEUTIC INFECTIOUS AGENTS

Live vaccines or therapeutic infectious agents should not be given with REMICADE® due to the possibility of clinical infections, including disseminated infections.

For more information, please see the full Prescribing Information and Medication Guide for REMICADE®. Provide the Medication Guide to your patients and encourage discussion.

REFERENCES

1. REMICADE® (infliximab) [Prescribing Information]. Horsham, PA: Janssen Biotech, Inc.


Please see Important Safety Information on pages 22 and 23.
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